Massachusetts Division of Health Care Finance and Policy
Health Safety Net Office

Health Safety Net INET Payment Reporting Form Instructions for Community Health Centers

(October 1, 2007)

GENERAL INSTRUCTIONS

All monthly Community Health Center (CHC) Payment Reporting Forms are to be submitted via DHCFP-INET, the Division's Web-based transaction system, no later than 45 days after the last day of the designated reporting period (e.g. August report due October 15). The Division reserves the right to compare statistics submitted on this form with data submitted on claims for the same reporting period and eligibility data reported in REVS and to withhold or adjust payments where there are significant discrepancies.

CHC's may only bill HSNO for eligible services provided to patients who have been approved for Health Safety Net (HSN) care and are in accordance with governing regulations 114.6 CMR 13.00 and 14.00. All patients for whom a CHC is submitting a Health Safety Net Office (HSNO) request for payment must be eligible for services as described in 114.6 CMR 13.00, determined through the MA-21 system, and appear in REVS.

If the patient is eligible for HSNO Secondary and has other insurance that covers the eligible service, then that other insurer must be billed first and HSNO may pay patient co-insurance balance (e.g., insurance says patient co-insurance is 20% of the charge), as long as the total received does not exceed the HSNO rate for the service. If a CHC has a contract with another payer, for example with a state agency or an HMO, to provide services at a rate lower than the rate paid by HSNO, the balance may not be billed to HSNO. Please refer to Attachment A for specific codes and effective rate reference documents. CHC's may not bill HSNO for residential services or for inpatient services other than those inpatient services explicitly listed in Attachment A. Requests for Urgent Care Bad Debt payment will be made through a separate INET application. For more information, please visit the Division's website www.mass.gov/dhcfp. Pharmacy claims will be processed through the MassHealth Pharmacy On-line Processing System (POPS).

Information should only be entered in the gray cells. Enter the total visits for each medical or behavioral health line item (lines 3-11); the total dollar amount and number of visits or procedures for dental services (lines 12-12B); each on-site ancillary line (lines 13-20A) for medically necessary services eligible for HSNO; and the various components of safety net care income (lines 22-24A). Please refer to the line by line instructions below for details.

Please include The Community Health Center Name and Month of service.

HSNO PAYMENT REPORTING FORM

Column Instructions:
Column A- Designated line item numbers.

Column B- Labels that describe the information for that line: safety net care eligibility categories(HSN[primary and secondary], HSN Partial, Medical Hardship), patient share, HSNO

share, medical and behavioral health visits (Medical, Surgeries, Urgent After-Hours Visit Add-On, Behavioral Health), Total Visits, item 11), dental payments and units of service (Payment for Procedure Codes other than D9450, Billable Dental Procedures, D9450 Add-Ons Billed), on-site ancillary payments and units of service (Laboratory, Radiology, Vision, Wellness, Cardiology and Pulmonary, Obstetric, Office Administered & Dispensed Vaccine, Drugs & Supplies, Total Ancillaries, item 21) and safety net care income (Recoveries of Prior Write-offs, Income from Grants, 3rd Party Payments/Medicare, etc., Visits corresponding with item 24, Total Safety Net Care Income, item 25) and Total HSNO Payment, item 26. *Please refer to specific line item instructions below for further details.*

Column C- The rate to be used in the calculation where the payment is based on a single rate times the number of eligible units entered in column D where applicable. Where "$ Amount" appears that indicates a dollar value is entered in that line. If that line is blank then entries for that line will be based on number of eligible procedures/units.

Column D- Total number of actual visits, prescriptions, amount of dollars of dental, on-site ancillary payments, and amount of dollars for safety net care income offsets. The numbers in these cells are a programmed calculation of the sum of the next 6 columns.

Columns E through I- Amounts to be reimbursed for full(HSN Primary and HSN Secondary) and partial safety net care in the percentages of 100%, 80%, 60%, 40%, 20% based on HSNO's share of payment defined below:

HSN (Primary and Secondary) - The number of visits or dollar amount for patients who are eligible for full safety net care payment for eligible services. Provider must follow patient and service eligibility rules described in 114.6 CMR 13.00.

HSN Partial - The number of visits or dollar amount attributed to partial safety net care at the various percentage levels based on the patient's income as a percentage of Federal Poverty Guidelines. Enter the total numbers in the gray cells and the form will calculate the proper percentage of payment depending on category which will appear totaled in column K. Please refer to 114.3 CMR 13.00 for percentages corresponding to the various Federal Poverty Guideline levels.

Column J- Medical Hardship- Please refer to 114.6 CMR 13.00 for criteria pertaining to medical hardship eligibility and allowable expenses that may be billed to HSNO. Enter the number of actual visits, actual dollar amounts for the on-site ancillary payments and safety net care income offset.

Column K-HSNO Payment- The numbers in these cells are a programmed summary calculation using the information entered in the previous columns. Items with single rates are calculated by taking the number of units times the rate times the HSNO eligibility percentage and added together. Items with multiple rates and consolidated payment amounts are multiplied by the appropriate eligibility percentage and summed.

Line Item Instructions:
Items 1-21 Pertain to Reimbursable HSN Services

Items 22-24A Pertain to Reductions (Offsets) to reimbursable HSN Amounts

Item 25 Pertains to Total Safety Net Care Income Amounts Reported by the CHCs

Item 26 Pertains to the Net Total for Payment

Item 1- Patient share: The percentage of HSN cost that is the patient's responsibility (0%, 20%, 40%, 60%, 80%).

Item 2- HSNO share: the percentage of HSN cost that is eligible for reimbursement by HSNO to the community health center (100%, 80%, 60%, 40%, 20%).

Medical and Behavioral Health Services
Item 3- Medical Visits: Enter in the appropriate column the number of eligible Medical Visits provided to HSN patients. There is a limit of one visit per patient per day unless the patient returns a second time for an entirely different medical problem. See Attachment A for specific CPT codes and servicing providers allowable for billing.

Item 4- Surgeries: Enter in the appropriate column the number of eligible surgical procedures provided to HSN patients. Only surgeries on days when no medical visit takes place can be billed to HSNO. See Attachment A for specific CPT codes and servicing providers allowable for billing.

Item 5-Urgent After-Hours Visit Add-on: Enter in the appropriate column the number of eligible units of service provided to the applicable category of HSN patients. The add-on can be billed in addition to the medical visit rate for **urgent care** visits provided on weekends or after 5:00 PM on weekdays or before 7:00 AM on weekdays.

Item 6- Behavioral Health-Individual Diagnostic Visits: Enter in the appropriate column the number of eligible units of service provided to the applicable category of HSN patients. See Attachment A for specific CPT codes and servicing providers allowable for billing.

Item 7- Behavioral Health-Individual Therapy at 40-50 Minute Visits Enter in the appropriate column the number of eligible units of service provided to the applicable category of HSN patients. See Attachment A for specific CPT codes and servicing providers allowable for billing.

Item 8- Behavioral Health-Individual Therapy at 20-30 Minute Visits: Enter in the appropriate column the number of eligible units of services provided to the applicable category of HSN patients. See Attachment A for specific CPT codes and servicing providers allowable for billing.

Item 9- Behavioral Health-Group Therapy Visits: Enter in the appropriate column the number of eligible units of service provided to the applicable category of HSN patients. See Attachment A for specific CPT codes and servicing providers allowable for billing.

Item 10- Behavioral Health-Medication Visits at 15-20 Minutes: Enter in the appropriate column the number of eligible units of service provided to the applicable category of HSN patients. See attachment A for specific CPT codes and servicing providers allowable for billing.

Item 11- Total Medical and Behavioral Health Visits: The numbers in these cells are automatically calculated within the form and represent the totals for each column.

Dental Services

Item 12- Payment for Dental Services: Procedure Codes (other than D9450: Enter in the appropriate column the sum of the fees for the eligible dental procedures provided to the applicable category of HSN patients. Fees are contained in the DHCFP regulation 114.3 CMR 14.00 Dental Services and are listed by specific CDT procedure code. See Attachment A for specific CDT codes and servicing providers allowable for billing.

Item 12A- Total Billable Dental Procedures (other than D9450): Enter the number of eligible dental procedures provided in the appropriate HSNO category. Although these entries do not form the basis of payment, this information is required and will be used to compare to claims data submitted separately for the billing period.

Item 12B- D9450 Add-on: Enter in the appropriate column the number of eligible units of service provided to the applicable category of HSN patients. The D9450 add-on can only be billed once per day per HSNO patient seen for allowable dental services.

On-site Ancillary Services

Item 13- Laboratory Payment: Enter in the appropriate column the sum of the fees for the eligible laboratory procedures provided to the applicable category of HSN patients. Fees are contained in the DHCFP regulation 114.3 CMR 20.00 Clinical Laboratory Services and are listed by specific CPT procedure code. See Attachment A for specific CPT codes allowable for HSNO billing.

Item 13A, Laboratory Procedures: Enter the number of eligible laboratory procedures provided in the appropriate HSNO category. Although these entries do not form the basis of payment, this information is required and will be used to compare to claims data submitted separately for the billing period.

Item 14- Radiology, Technical Component Payment: Enter in the appropriate column the sum of the fees for the eligible radiological technical component procedures provided to the applicable category of HSN patients. Fees are contained in the DHCFP regulation 114.3 CMR 18.00 Radiology and are listed by specific CPT procedure code. See Attachment A for specific CPT codes allowable for HSNO billing. **NOTE**: Dental x-rays are to be included under Dental services.

Item 14A- Radiology, Technical Component Procedures: Enter the number of eligible laboratory procedures provided in the appropriate HSNO category. Although these entries do not form the basis of payment, this information is required and will be used to compare to claims data submitted separately for the billing period.

Item 15- Radiology, Professional Component Payment: Enter in the appropriate column the sum of the fees for the eligible radiological professional component procedures provided to the applicable category of HSN patients. Fees are contained in the DHCFP regulation 114.3 CMR 18.00 Radiology and are listed by specific CPT procedure code. See Attachment A for specific CPT codes allowable for HSNO billing. **NOTE**: Dental x-rays are to be included under Dental services.

Item 15A- Radiology, Professional Component Procedures: Enter the number of eligible laboratory procedures provided in the appropriate HSNO category. Although these entries do not form the basis of payment, this information is required and will be used to compare to claims data submitted separately for the billing period.

Item 16- Vision, Diagnostic Visits: Enter in the appropriate column the number of eligible Visual Diagnostic Visits provided to HSN patients. Multiple diagnostic tests can be included in a single visit. There is a limit of one visual diagnostic visit per patient per day. See Attachment A for specific CPT codes and servicing providers allowable for billing.

Item 16A- Vision, Fitting and Dispensing Payment: Enter in the appropriate column the sum of the fees for the eligible fitting, dispensing procedures and dispensed products provided to the applicable category of HSN patients. Fees are contained in the DHCFP regulation 114.3 CMR 15.00 Visual Services and are listed by specific CPT or HCPC procedure code. See Attachment A for specific codes allowable for HSNO billing.

Item 16B- Vision, Fitting and Dispensing Procedures: Enter the number of eligible fitting and dispensing procedures and dispensed products provided in the appropriate HSNO category. Although these entries do not form the basis of payment, this information is required and will be used to compare to claims data submitted separately for the billing period.

Item 17- Wellness Payment: Enter in the appropriate column the sum of the fees for the eligible wellness services provided to the applicable category of HSN patients. These services are not included in the visit rate and may be billed in addition to a visit when the patient receives these services on a day when he/she is also seen for a medical visit. Fees are contained in the DHCFP regulation 114.3 CMR 17.00 Medicine and are listed by specific CPT or HCPC procedure code. See Attachment A for specific codes allowable for HSNO billing.

Item 17A- Wellness Procedures: Enter the number of eligible wellness procedures provided in the appropriate HSNO category. Although these entries do not form the basis of payment, this information is required and will be used to compare to claims data submitted separately for the billing period.

Item 18- Cardiology and Pulmonary Payment: Enter in the appropriate column the sum of the fees for the eligible cardiology and pulmonary services provided to the applicable category of HSN patients. Fees are contained in the DHCFP regulation 114.3 CMR 17.00 Medicine and are listed by specific CPT code. See Attachment A for specific codes allowable for HSNO billing.

Item 18A- Cardiology and Pulmonary Procedures: Enter the number of eligible cardiology and pulmonary procedures provided in the appropriate HSNO category. Although these entries do not form the basis of payment, this information is required and will be used to compare to claims data submitted separately for the billing period.

Item 19- Obstetric Delivery Payment: Enter in the appropriate column the sum of the fees for the eligible obstetric delivery services provided to the applicable category of HSN patients. Fees are contained in the DHCFP regulation 114.3 CMR 16.00 Surgery and are listed by specific CPT code. See Attachment A for specific codes allowable for HSNO billing.

Item 19A- Obstetric Delivery Procedures: Enter the number of eligible obstetric delivery procedures provided in the appropriate HSNO category. Although these entries do not form the basis of payment, this information is required and will be used to compare to claims data submitted separately for the billing period.

Item 20- Office Administered & Dispensed Vaccine, Drugs, & Supplies Payment: Most office administered vaccines, drugs and supplies are included in the medical visit payment. Use this category to report vaccines, injectables and supplies administered or dispensed to patients in the office on days when this is the only service provided. Enter in the appropriate column the sum of the fees for the eligible office administered and dispensed vaccines, drugs and supplies provided to the applicable category of HSN patients. These lines are not to be used for pharmacy services. Fees are contained in the DHCFP regulation 114.3 CMR 17.00 Medicine and are listed by specific CPT code. See Attachment A for specific codes allowable for HSNO billing.

Item 20A- Office Administered & Dispensed Vaccine, Drugs, & Supplies Units: Enter the number of eligible office administered vaccines, drugs and supplies provided in the appropriate HSNO category. Although these entries do not form the basis of payment, this information is required and will be used to compare to claims data submitted separately for the billing period.

Item 21-Total Ancillaries: The number in this cell is automatically calculated within the form and represents the total expected on-site ancillary payment for the reporting period.

Item 22- Recoveries of Prior Write-offs: are for prior write-offs of charges to HSNO that are recovered at a later date.

Item 23- Income from Grants: income received by the CHC from Grants. Centers will be specifically instructed when to use this line.

Item 24- 3rd Party Payments/Medicare, etc: HSNO is the payer of last resort and other insurers are considered primary and must be billed first. All patients for whom the CHC is submitting a HSNO request for payment must be eligible for services as described in 114.6 CMR 13.00. Enter

any payments received by 3rd party, Medicare, other insurance, etc., made to the CHC. When payments are greater than the HSNO fee, the amount up to that fee is the offset. Co-payments are the responsibility of the patient and may not be billed to HSNO. The CHC should enter the full information within lines 3-20A and then report the payment received from the insurer as safety net care income. If the patient is HSNO secondary the CHC may bill HSNO for the services if the services are to count toward a deductible. However, it is the responsibility of the CHC to ensure that once the deductible is met that HSNO is no longer billed for the services or HSNO is only billed for appropriate co-insurance.

24A Visits corresponding with item 24: Any visits pertaining to item 24 should be recorded on this line.

Item 25- Total Safety Net Care Income: The number in this cell is automatically calculated within the form and represents the total offsetting income for the reporting period.

Item 26- Total HSNO Payment: The number in this cell is automatically calculated within the form and represents the maximum amount of funds to be paid to the CHC for the reporting period.